

budget. New treatments, newly discovered needs, even new diseases can no longer be attacked by increasing the share of resources allocated to health care. More resources for one item can be developed only by reducing the resources spent on other items. Since the dollars available through health alliances will be constrained (rationed), care may also be constrained (rationed) unless the system becomes more efficient.

Under a fixed budget, the amount of health care available to the population becomes a direct function of the efficiency and effectiveness of the health care delivery system—how much bang is available from each limited buck. Ineffective delivery systems mean more waste and consequently less care. Physicians, as well as hospitals and others in the health care field, will now have a direct responsibility to society to organize systems to provide the best and most efficient care this fixed budget will allow. Physicians must accept the responsibility to be active participants in the design and management of these systems, rather than leave this to those with less understanding of health care delivery. Physicians must also show that they are a profession interested in the well-being of all Americans, as well as their own patients, and that they can do a better job under the constraints of fixed resources than bureaucrats, politicians, and other experts.

If physicians passively participate in systems in which they simply accept fees, or even negotiate fees, but accept no responsibility for making the system work, they will lose control over their practices. The payer—be it an insurance company or a single-payer government scheme—that takes the risks for access, costs, and quality must protect itself against these risks through micromanagement of physicians' practices. If, on the other hand, physicians accept responsibility and risks, control of the delivery system should lie with them as it does in some programs today.

I would say to Dr Auerback that if physicians manage managed care, the art and soul of medicine have a better chance of being preserved than if that management is turned over to others, regardless of how well-intentioned the others may be. The amount of art and soul that can be built into these systems will depend on the values of the physicians, the benefit to patients of these values, the degree of influence physicians have on the system, and the ability of the system to free up resources to support these desirable practices.

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REFERENCE

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Who Will Manage Patient Care?

MARVIN AUERBACK, MD, provides a cogent argument to support his conclusion that "the face of American medicine, its art, and perhaps its soul, will likely be changed forever." Although there are many reasons for the changes, few practicing physicians would deny that managed

care is a major cause of the alterations in health care delivery and practice styles outlined by Dr Auerback. Few would also deny that major reform is needed.

Costs that are out of control—rapidly approaching 14% of our gross national product—and limited and unequal access to health care are problems that trickle down to shrink the pocketbook of all Americans and the quality of life of many. So the question we must ask is not should we fix the health care system, but how? And can we do it without threatening, perhaps destroying, the physician-patient relationship, which is so vital to the well-being of patients? Managed care has yet to provide an answer to either question.

Managed care systems are not homogeneous, but they are all based on the premise that medicine is and should be a business. This premise threatens the mutual confidence and trust between patients and physicians, both essential ingredients of successful patient care. This premise and the operational rules it requires threaten the autonomy of physicians as they make even minor decisions in day-to-day patient care and, more important, the autonomy of sick patients as they struggle to decide their own fate.

"Case managers" play an important role in managed care systems. They are seldom physicians, they never see patients, and they have no responsibility for the welfare of patients. They have a responsibility to their employer: the managed care plan. Their job is to save money for their employer by micromanaging physicians' decisions and, in turn, patients' illnesses. Not long ago I admitted a patient to hospital for placement of a Tenckhoff peritoneal catheter for permanent dialysis. Sometimes we can admit patients for this procedure and send them home in the evening. Sometimes it is in their interest to stay overnight. In this instance the patient had more pain than usual, along with severe vomiting, and we kept her an extra night. I received a call from a case manager at the patient's insurance company saying that he was "disallowing" the extra day's stay. I asked the person if he knew what a Tenckhoff catheter was, if he had seen patients with them, if he knew the possible complications of catheter placement, or if he had ever seen a patient with end-stage renal disease, let alone cared for one. The answer to all of the questions was "no." Not once in our conversation did he ask whether or not the patient benefited from the extra day in the hospital or whether or not she had recovered from her pain and vomiting.

The emphasis on the bottom line is placing pressure on physicians to act more like businessmen and businesswomen and less like patient advocates. Terms like competition and marketing are becoming required vernacular. We are being asked, indeed forced, to make bedside decisions based not on what is best for our patients, but on what is best for insurance companies and managed health care plans.

The practice of medicine is not in the most basic sense a business. Our job is not to sell goods or services, whether patients need them or not; nor should we be expected to make decisions about patient care based on profit mo-

tives. Our responsibility is to provide patients with health care and to act as their advocate in time of conflict with institutions and agencies that threaten the quality of the health care we provide. This responsibility should not be dependent on any expected financial gain. It is a hallowed tradition that is essential to our patients' well-being. It is the reason for our existence. It is the "soul" of medicine, and if the "soul" is changed, as Dr Auerback suggests, it will be our patients, not ourselves, who will suffer the greatest loss.

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Overcoming Managed Care Blues

YES, AS SUGGESTED IN Marvin Auerback's lucid essay, managed care does threaten to harm the soul of medicine and blight our spirits . . . but only if we let it. As we adapt to monopolistic, Big Brother medicine, my antidote for our melancholy is to look for honest pleasures in our lives and build on them. Our cardinal pleasure is the one that we should cultivate the most, that which comes from

working through clinical problems and making the best decisions for our patients. This well will never run dry. In parallel, we can seek out and do new and different things in our practices. Life is change; change excites. Take a course in echocardiography or come to grips with likelihood ratios and the probability game.

We have come to depend too much on reports about our patients gathered by others. We cannot see our patients for the data. The remedy is to do more things that are concrete, immediate, and palpable—touch, take our patients' blood pressure measurements ourselves, look at x-ray films ourselves. This can give us a sense of command, understanding, and closeness to a patient that can be gained in no other way.

We are too insular. There is much to gain by going outside medicine and viewing the world through the spectacles of others. Regular participation in nonmedical discussion groups can be salutary for physicians. By going outside, we get inside. And we have our families, hobbies, and sports—tennis, anyone?

Cheer up, comrades, there are shoals ahead, but our lives and managed care do not have to be unmanageable.

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